TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Luciano Gaigher, D.C.

Respondent Name
Hartford Underwriters Insurance Company

MFDR Tracking Number
M4-16-2308-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 6, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE CURRENT RULES ALLOW REIMBURSEMENT"

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "02/17/16 – Payment issued in the amount of $900… Reimbursement issued for the following:

- MMI exam $350
- IR $50
- Extent of injury exam $500"

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 12, 2016	Designated Doctor Examination	$300.00	$300.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

- 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was also performed.
- 247 – A payment or denial has already been recommended for this service.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. What are the services in dispute?
2. Is the insurance carrier's reason for denial of payment supported?
3. What is the maximum allowable reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor submitted a Medical Fee Dispute Resolution Request (DWC060) that included a designated doctor examination of maximum medical improvement and impairment rating, represented by procedure code 99456-W5-WP; a designated doctor examination to determine whether the injured employee's disability is a direct result of the work-related injury, represented by procedure code 99456-W7-RE; and a designated doctor examination to determine the ability of the injured employee to return to work, represented by procedure code 99456-W8-RE. Subsequently, the requestor advised that they received payment in full for procedure codes 99456-W7-RE and 99456-W8-RE. The requestor submitted an amended DWC060 indicating that they are only seeking reimbursement of $300.00 for procedure code 99456-W5-WP at this time. Therefore, this is the only service that will be considered for this dispute.
2. The insurance carrier reduced the disputed services with claim adjustment reason code 4150 – "AN ALLOWANCE HAS BEEN PAID FOR A DESIGNATED DOCTOR EXAMINATION AS OUTLINED IN 134.204(J) FOR ATTAINMENT OF MAXIMUM MEDICAL IMPROVEMENT. AN ADDITIONAL ALLOWANCE MAY BE PAYABLE IF A DETERMINATION OF THE IMPAIRMENT CAUSED BY THE COMPENSABLE INJURY WAS ALSO PERFORMED."

   Review of the submitted documentation finds that the Report of Medical Evaluation (DWC069) and physician's narrative include findings of a permanent physical impairment. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
3. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204(j)(4), "The following applies for billing and reimbursement of an IR evaluation. … (C)(ii) The MAR for musculoskeletal body areas shall be as follows. … (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." The submitted documentation supports that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the lumbar spine. Therefore, the correct MAR for this examination is $300.00.
4. The total MAR for the disputed service is $650.00. The insurance carrier paid $350.00. An additional reimbursement of $300.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $300.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 25, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.